AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For Health Care Financing / Children's Health Insurance Program To Disclose Information)

		/ /
Client Name	Social Security #	Date of Birth
Ι		hereby authorize the
(Client or Personal Representative)		
Utah Department of Health, through its Division of I	Health Care Financing to disclose	e specific health information
from the records of the above named client to:		
from the records of the above named client to:(Pe	erson or Organization Receiving	the Information)
The specific health information authorized for disclo	osure is:	
The purpose of the disclosure is:		
I understand that this authorization will expire on the	e following date, event, or condit	ion:
I understand that if I fail to specify an expiration date time needed to fulfill its purpose. I also understand twritten notification to Privacy Officer indicated in the duplicate Notice of Privacy Practices can be provide understand that a revocation is not effective to the exthe disclosed health information.	that I may revoke this authorization to Notice of Privacy Practices alroad upon request when filling out to	on at any time, by sending eady provided to the client (a his authorization). I
I understand that I may refuse to sign this authorization Financing cannot deny or refuse to provide treatmen benefits if I refuse to sign this authorization.		
I understand that, once information is disclosed purs be protected by medical privacy laws and could be re		
By signing, I acknowledge I have been provided a co	opy of this signed authorization.	
	/	
Signature of Client or Authorized Representative	Date	
If signed by an Authorized Representative, a descrip	tion of authority to serve:	